

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2010
NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38585		
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F 000	INITIAL COMMENTS A Comparative Federal Monitoring Survey was conducted at Generations Center of Spencer February 22-26, 2010. The facility was found not in substantial compliance with Medicare regulations at 42CFR 483.5-483.75- Subpart B-Requirements for Long Term Care Facilities. The following deficiencies resulted in the facility's non-compliance. The facility's census was 67. It was determined the provider's non-compliance with one or more requirements of participations had caused, or was likely to cause, serious injury, harm, impairment, or death to residents, and existed as of February 24, 2010, at 2:20 p.m. The immediate jeopardy was related to non-compliance with 483.25 Quality of Care, and 483.75 Administration.	F 000			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, group interview and staff interview, the facility failed to ensure survey results were posted in a place readily accessible to residents and failed to post a notice of their	F 167	The facility failed to ensure the survey results were posted in a place readily accessible to residents and failed to post a notice of their availability. A copy of the survey results were moved from the front lobby the nurses' station on 02/25/10 to provide immediate viewing access to residents. The copy was moved to 200 hall wall approximately (3) three feet from the floor on 03/09/10 to ensure access and availability to survey results. The new location will be monitored weekly during safety check by the safety officer to ensure the results continue (cont. next page)	03/09/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 availability. Eight (8) of eight (8) residents in the group complained they were unaware of the survey results. The findings include: 1. During the group interview, conducted 2/24/10, beginning at 9:30 a.m., eight (8) of eight (8) residents in attendance stated they were unaware of the location of the survey results. All eight residents stated they would be interested in reading the report. 2. During the Environmental Tour, conducted 2/24/10, beginning at 2:20 p.m., the Safety Officer (SO) stated the survey results were located in the lobby, behind the receptionist's desk. The SO further stated you must enter a code in order to exit to the lobby. 3. On 2/25/10 at 8:50 a.m., the survey results were observed hanging on the wall, behind the receptionist's desk in the main lobby of the facility. The survey results were in a binder, which was positioned approximately five (5) feet from the ground. The survey results were not accessible to wheelchair bound residents or any other residents who did not know the code to exit into the front lobby. Interview with the receptionist at the time of the observation revealed she was unaware of any resident coming into to lobby on a regular basis, and no one had asked her to see the survey results.	F 167	(cont. from previous page) at site placed. The safety officers findings will be re- viewed at the monthly quality assurance meeting, if issues are found with placement. REQUIRED REVISION Each resident was informed of the new location of the survey results on 03/09/10 by social services. (see attachment #1) Residents will be informed on admission of location of survey results. The safety officer will monitor the location of the survey results weekly for the next 90 days and monthly there- after.	03/09/10	03/18/10
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226	The facility failed to investigate injuries of an un- known origin on resident #1 and #16. There was no immediate (cont. next page)	03/01/10	

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F 226	<p>Continued From page 2 and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, record review and staff interview, the facility failed to ensure injuries of unknown origin were investigated for two (2) of twenty (20) sampled residents (Resident #'s 1 and 16) and an incident of an altercation involving two (2) of twenty (20) sampled residents (Resident #'s 5 and 19) was investigated according to facility policy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Resident #1 was admitted to the facility 12/27/07 with diagnoses of Schizophrenia with Psychosis, Anxiety, Multiple Delusions, Lupus and Obesity. Review of the Minimum Data Set (MDS) dated 12/3/09 revealed the resident had moderately impaired decision making skills, exhibited wandering behaviors and required limited assistance with activities of daily living. Review of the Nurse's Notes dated 12/14/09 revealed a large red area was found on the upper arm of Resident #1. <p>Review of the facility's "Abuse Investigations" Policy revealed, "Should an incident or suspected incident...or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident."</p> <p>Interview with the Assistant Administrator (AA) and Director of Nursing (DON) on 2/24/10 at 11:15 a.m., revealed the reddened area on the resident's arm would be considered suspicious.</p>	F 226	<p>(cont, from previous page)</p> <p>corrective action as the incident occurred on 12/04/10. A follow up investigation was concluded on 03/01/10 by the administrator and director of nursing to rule out the possibility of abuse, neglect, or mistreatment. None were identified. All incidents resulting in injury of an unknown origin will be immediately reported to the administrator. The investigation conducted by the administrator will follow the abuse investigation procedures (see attachment A). The administrator and director of nursing will make recommendations for the corrective action if needed. Copies of the reports will be filed in the front office. All incident reports will be reviewed by the administrator within 72 hours. The quality assurance committee will survey 10% of all incident reports and follow up investigations monthly to ensure proper implementation of policy and procedure.</p> <p>The incident occurring on 12/26/09 between resident #5 and resident #19 requires no immediate corrective action. All incidents involving resident to resident altercations</p> <p>(cont. next page)</p>	03/01/10	

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F 226	Continued From page 3 The AA indicated no investigation had been conducted to determine how the reddened area occurred. 2. Resident #16 was admitted to the facility 6/30/06 with diagnoses of Alzheimer's Disease, Depression, Hypertension, Type II Diabetes and Confusion. Review of the resident's most recent MDS, dated 2/8/10, revealed he had severely impaired decision making skills, required extensive assistance with all activities of daily living and had short and long term memory problems. Resident #16 was observed on 2/22/10, at 2:30 p.m. during the initial tour. He had a large, purple bruise under his left eye. Review of the Nurse's Notes dated 2/19/10 revealed the nurse noticed the bruise under the left eye. The nurse indicated she asked him what happened and he stated he bumped his eye on the side rail. The nurse did not report the injury of unknown source to the Administrator per the facility policy. There was no investigation completed per the facility policy to determine how the cognitively impaired resident sustained a black eye. During an interview with the AA on 2/25/10 at approximately 4:00 p.m., she confirmed no abuse investigation had been completed. 3. Resident #5 was admitted to the facility 10/6/06 with diagnoses of Bipolar Disorder, Depression, Insomnia, Obesity, Status Post Cerebral Vascular Accident with left-sided Hemiparesis and Hypertension. Review of the MDS dated 2/4/10 revealed she required supervision with ambulation, and some difficulty making decisions in new situations. The resident was identified as interviewable by the facility.	F 226	(cont. from previous page) resulting in injury will be reported to the administrator, the resident's responsible party, and the residents physician immediately. The resident to resident abuse policy (see attachment B) will be followed. A weekly meeting will be held between the director of nursing, administrator, and social workers to review all resident to resident altercations and investigations. The safety committee will review findings monthly for patterns in behaviors and policy implementation. The safety committee will report changes to the quality assurance committee monthly REQUIRED REVISION The outcome resolution for resident #1- resident #1 was interviewed by the director of nursing on 03/11/10. The resident denies abuse, or resident to resident altercation, but stated the incident was too far back to remember. The staff interviews conducted uncovered no suspicion of abuse (see attachment 2 for copies of completed investigations). The Ombudsman was notified of completion of abuse investigation. (cont. next page)	03/01/10	03/19/10

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F 226	Continued From page 4 During an interview on 2/23/10, at 4:10 p.m., Resident #5 stated Resident #19 had hit her in the face in December 2009. The resident said, "I don't know what it is, but when someone gets mad, they hit me! It's like a have a sign on me!" The resident stated she didn't think anything happened after the incident and Resident #19 had not hit her again. Review of the "Alleged Incident/Accident Report", dated 12/26/09, revealed the facility was aware of the altercation between the two (2) residents. The space for the DON and Administrator to sign, indicating the incident had been reviewed by them was blank. Review of the "Protection of Residents During Abuse Investigations" policy revealed if alleged abuse involved two (2) residents, the accused resident's representative and attending physician would be informed and the accused resident would not be permitted to make visits to other resident's rooms unattended. There was no evidence the facility implemented this policy. Interview with the AA on 2/25/10 at approximately 5:00 p.m., confirmed no investigation had been conducted related to the altercation, according to the policy.	F 226	(cont. from previous page) on 03/19/10. The quality assurance committee will review all resident investigations monthly indefinitely. The staff was retrained on how to identify injuries of an unknown origin and reporting procedures on 03/19/10 by social services. The abuse policy came from a manual of abuse procedures. It was reviewed on 03/18/10 for use by the quality assurance committee. (See attachment 3).	03-19-10
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	The facility failed to ensure resident #13 was not exposed during transport from the dining room to his room. The facility failed to avoid the use of styrofoam cups during meals and failed to clean the dining (cont. next page)	03/11/10

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F 241	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to ensure one (1) of twenty sampled residents (Resident #13) was not exposed during transport from the dining room to the his room. The facility failed to avoid the use of Styrofoam cups for four (4) of four (4) meals observed and failed to clean the dining room table and floor between the first and second seatings of lunch for one (1) of four (4) meals observed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Resident #13 was admitted to the facility on 2/16/05 with diagnoses of Schizophrenia, Dementia, Alzheimer's Disease, Behavioral Disturbance with History of Violence, Mild Mental Retardation, Cognitive Impairment, Depression, Tardive Dyskinesia, Seizures and Osteoarthritis. The resident was coded on his most recent Minimum Data Set (MDS) dated 12/31/09 as requiring extensive assistance with dressing and hygiene, as well as frequent incontinence of bladder. <p>During an observation on 2/23/10 at 5:50 p.m., Resident #13 was transferred by CNA A from the dining room with his pants pulled down approximately five (5) inches, exposing the upper portion of his buttocks and part of his adult incontinence briefs. There were multiple residents and staff members in the dining room and hallway.</p> <ol style="list-style-type: none"> 2. During the meal observation on 2/23/10 at 12:00 p.m., sixteen (16) residents in the dining room were served beverages in Styrofoam cups. 	F 241	<p>(cont, from previous page)</p> <p>room tables and floors between meals. All staff were in-serviced on 03/09/10 through 03/11/10 on the promotion of dignity in the long term care setting. All styrofoam cups were removed from all meals on 02/26/10. On 02/26/10, the cleaning system was reorganized to include: proper sanitation of each table before residents on the second dining schedule are assisted to the tables. The floors will be swept and mopped between dinings to insure dignity and proper sanitation. The maintenance director and dietary manager will monitor the new system daily for the first week and then weekly thereafter for compliance. The administrator will conduct at random to ensure compliance.</p> <p>.....</p> <p>REQUIRED REVISION</p> <p>The in-service conducted from 03/11/10 on the promotion of dignity in long term care covered the following information:</p> <ol style="list-style-type: none"> 1. Grooming residents as they wish to be groomed 2. Assisting residents to dress to dress in their own clothes appropriately to the time of day and with individual preference <p>(cont, next page)</p>	03/11/10	03/11/10

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F 241	Continued From page 6 Three (3) additional meal services were observed in the dining room on 2/23/10 (12:50 p.m. and 5:10 p.m.) and 2/24/10, 12:05 p.m.. Residents continued to be served beverages in Styrofoam cups. During an interview with the Dietary Manager on 2/24/10 at 4:05 p.m., she stated the facility was short of glasses and Styrofoam cups were used at every meal as a result. 3. During the meal observation on 2/23/10 at 12:50 p.m., seven (7) restorative residents were transported into the dining room for lunch and five (5) of eleven (11) tables had not been cleaned after the first seating. Dirty dishes and food debris were left on the tables and floor. During interview on 1/24/10 at 4:05 p.m., the Dietary Manager (DM) confirmed the tables and floors should have been cleaned prior to the second (2nd) seating of lunch residents entering the dining room.	F 241	(cont, from previous page) and ensure clothing is properly fitting 3. Promote resident independence during dining to avoid using plastic ware and promote a pleasant dining experience 4. Respect residents privacy, space and property 5. Respect residents social status 6. Focus on residents as individuals when you talk to them The in-service on dignity was conducted by supervisory staff and a copy of material covered was provided to each staff member. (see attachmnet 4) The staff was educated on the updated cleaning system by the maintenance director and director of nursing from 03/01/10 through 03/11/10. (see attachment 5) The maintenance director will attend the quality assurance committee and discuss any issues that arise with current cleaning system. The quality assurance committee will complete the basic hygiene/dignity form (see attachment 6) monthly. The quality assurance nurse will look at 100% of residents for the first 30 days to ensure dignity and 10% of residents census thereafter for compliance. (F 244 to begin on next page)	03/11/10	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview and record review, the facility failed to address resident grievances about the recent facility smoking policy change which impacted	F 244			

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F 244	<p>Continued From page 7</p> <p>fourteen (14) of fourteen (14) smoking residents. In addition, eight (8) of eight (8) residents in the group interview complained soup and sandwiches were served too frequently and the facility had not addressed the concern.</p> <p>The findings include:</p> <p>1. During a resident interview on 2/23/10 at 5:45 p.m., Resident #20 shared she felt the residents had no rights since the facility recently stopped allowing residents to have a 6:00 p.m. smoking break. During the group interview on 2/24/10 at 9:30 a.m., the residents communicated they would like the facility to return the "after dinner" smoking break at 6:00 p.m. The residents further explained the facility recently discussed allowing two cigarettes during smoke breaks when inclement weather was in the forecast; however, the facility did not discuss deleting the "after dinner" smoke break. One resident said, "What we say and what they do are two different things." The entire group expressed residents had no input in facility rules. Resident #11 stated residents should be allowed to smoke five (5) times daily if they can afford it. Resident #5 communicated the residents were tricked because the residents only agreed to the smoking policy revision due to bad weather (the residents didn't agree nor discuss omitting the 6:00 p.m. smoking break).</p> <p>The Resident Council minutes dated 1/5/10, confirmed discussions occurred in reference to allowing two cigarettes at a time during smoking breaks during bad weather. The Resident Council minutes dated 2/2/10, indicated that an emergency council meeting occurred on 1/6/10 with all smoking residents to review and sign smoking policy revision for inclement weather</p>	F 244	<p>(F 244 to begin)</p> <p>The facility failed to address the resident grievances about the recent facility smoking policy changes and soup and sandwiches being offered too frequently on the menu. A meeting was held on 03/03/10 to discuss smoking policy, menus, complaints and grievance procedure. Social workers, activities director and all residents who wished to join were in attendance. Social workers reviewed information in rooms with residents who did not attend the meeting. Changes were made per resident request to current policy. No further complaints were noted. The residents were notified the dietary staff will complete a menu substitution log (see attachment C). The menu substitution log will be reviewed monthly by the administrator to ensure no food items were being too frequently. All complaints and grievances will be reviewed by administrator within 24 hours. The social workers will review complaints and grievances investigations monthly and all findings will be reported to the quality assurance committee monthly.</p> <p>..... (cont. on next page)</p>	03/03/10	

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F 244	<p>Continued From page 8 situations.</p> <p>During interview on 2/25/10 at 9:50 a.m., the Director of Nursing (DON) and Assistant Administrator (AA) stated if residents are allowed to smoke during the 6:00 p.m. smoking break, they would run out of cigarettes prior to the end of the month. In addition, the DON and AA shared residents were allowed to smoke at 6:00 p.m. during the summer.</p> <p>Review of the "Smoking Policy" dated 3/31/08, revealed four (4) supervised smoking breaks were scheduled at 8:00 a.m., 11:00 a.m., 2:00 p.m. and 4:00 p.m. This change occurred due to an increase in the price per carton of cigarettes.</p> <p>2. During the group interview on 2/24/10 at 9:30 a.m., eight (8) of eight (8) complained soup was served several times a week. All eight residents stated after having soup and sandwiches for the evening meal, they became hungry during the night. The residents stated they felt light meals should be served at noon and heavier meals served in the evening. The residents further stated the facility had been made aware of their concerns during a council meeting. Although the resident council president stated the facility was aware of concerns about the menus, those concerns had not been recorded in the council minutes.</p> <p>Review of the three (3) week menu cycle confirmed the facility served soup 2-3 times per week. On 2/23/10, the facility made a menu change due to a specific menu item had not been shipped. The Dietary Manager (DM) stated she contacted the consultant dietitian and she approved the menu to serve soup and</p>	F 244	<p>(cont. from previous page)</p> <p>.....</p> <p>(See attachment 6-1) for copy of updated smoking policy, the change was made to the afternoon time from 2:00 p.m. to 1:30 p.m. As the facility reviews complaints and grievances the following policy will be followed (See attachment 7). The facility will review policy changes that directly affect the residents during the monthly resident council meeting to ensure resident awareness in policy changes.</p>	03-03-10	

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F 244	Continued From page 9 sandwiches. The DM did not have a record of how often menu substitutions were made or if the consultant dietitian approved the changes to ensure nutritional adequacy. During interview on 1/24/10 at 4:05 p.m., the DM confirmed the residents received soup several times per week. The DM also stated she was working to provide meals by resident choice.	F 244			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure personal items were labeled in one (1) of two (2) shower rooms (100/200 hall shower room). The findings include: During the initial tour of the facility, on 2/22/10, with the Assistant Director of Nursing (ADON) present, the following concerns were identified: There were six (6) bottles of deodorant stored in a cabinet with no label or date. There were three (3) hair brushes, with long gray hairs in the bristles, that were not labeled. The ADON stated all items should have the resident's name and room number. She also stated unlabeled items should not be stored in a common area where available for use by multiple residents.	F 253	The facility failed to ensure personal items were labeled in the shower room on 100/200 hall. The nursing department removed all unlabeled items from the 100/200 hall shower room on 02/23/10. Labeled items were replaced by central supply, individualized into bags and stored in a secure location on 02/23/10. The 400 hall shower room was checked by the director of nursing, all items were labeled appropriately. The safety officer will conduct a weekly walk through to include shower rooms to monitor for labeling. The director of nursing will complete a monthly inspection of shower rooms to monitor compliance. REQUIRED REVISION All staff were retrained to monitor for new items brought in by visitors (see attachment 8). The training was conducted (cont, next page)	03/01/10	
F 254	483.15(h)(3) CLEAN BED/BATH LINENS IN	F 254			

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F 254 SS=E	<p>Continued From page 10 GOOD CONDITION</p> <p>The facility must provide clean bed and bath linens that are in good condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 23 of 35 towels observed in the 100/200 hall shower room were clean, and six (6) of six (6) wash cloths were clean and in good condition.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the initial tour of the facility, on 2/22/10 at 2:20 p.m., with the Assistance Director of Nursing (ADON), five (5) of five (5) bath towels in the 100/200 hall shower room were a dingy, yellow color. The ADON stated the towels were used to dry residents' after a shower and agreed the towels looked dingy. 2. On 2/26/10 at 8:00 a.m., 18 of 30 bath towels stored for use in the 100/200 hall shower room were observed with a dingy, yellowish hue. Six (6) of six (6) wash cloths in the same shower room were dingy and thread bare. When held up, the wall could be seen through the wash cloths. 3. Interview with the Maintenance Supervisor (MS) on 2/25/10 at 8:40 a.m., revealed the facility did laundry in house, and used commercial washing machines. The MS stated the washing machines had the chemicals automatically dispensed for each load. There was a container of household laundry detergent located on top of the commercial washing machine. Upon inquiry, 	F 254	<p>F 253 (to cont. this page)</p> <p>by Assistant Administrator. The social services department was primarily responsible for labeling in the past. The new procedure educates all staff on monitoring and labeling and utilizes the housekeeping department for daily monitoring for compliance. It also provides a monitoring tool for evaluation of proper labeling (see attachment 9). The safety officer will continue to complete a review of proper labeling weekly as policy and the director of nursing will conduct monthly inspections for 6 months. The quality assurance committee will review for changes in time frames following 6 months.</p> <p>F 254 (to begin)</p> <p>The facility failed to provide clean bed and bath linens that were in good condition. The laundry department assessed all linens in house for condition on 02/26/10. Linens in poor condition were discarded. New linens were placed on 02/27/10. The laundry workers will discard linens as stains, tears, or thread bear areas are noticed. The maintenance director will conduct quarterly evaluations of linens placed in hall carts to ensure they are in</p> <p>(cont. next page)</p>	03/01/10	

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F 254	Continued From page 11 the MS stated the facility had run out of the automatically dispensed detergent of 2/24/10 and he had purchased the household detergent to use in the interim. The MS indicated the laundry workers put 1/4 of a capful of the household detergent into each wash load. Review of the product information on the container revealed "Fill cap to the fourth line for regular loads." The MS stated typically the commercial washer held a larger load than a household washer. There was no policy or procedure for laundry staff to utilize in case of an emergency or when they ran out of commercial detergent. There was no way to determine if the correct amount of detergent was being used for each load of laundry.	F 254	(cont. from previous page) good condition. The facility failed to create a policy and procedure for use of household detergents in emergencies, where there is no commercial detergent available. A policy was written 03/07/10. A policy was written on 03/09/10. Maintenance, laundry and housekeeping staff were educated on new policy on 03/09/10. The maintenance director will notify the administrator of each instance where the household detergent is		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	used. REQUIRED REVISION The laundry staff was educated on the maintenance of bed and bath linens on 03/09/10 by Assistant Administrator. A copy of the household detergent policy is included (see attachment 10). The washing machine holds 82 gallons compared to a regular household machine of 33 gallons. The amount to be used is 2 1/2 cups. A weekly monitoring tool has been developed to ensure there is commercial detergent in house at all times. The housekeeping supervisor will complete the detergent inventory log weekly (see attachment 11). The facility recieved commercial (cont. next page)	03/09/10	

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F 272	<p>Continued From page 13</p> <p>and sustained a hematoma below her eye and on her left hand. Review of the "Falls Investigation Worksheet" revealed on 8/25/09 a seatbelt was applied for Resident #1 when up in her wheelchair. There was no documentation an assessment had been completed to ensure this was least restrictive device or if it was medically necessary. The resident sustained additional falls, without injury on 9/1/09 and 12/30/09.</p> <p>Interview with the Assistant Administrator (AA) and the Director of Nursing (DON) on 2/24/10 at 11:00 a.m., revealed there was no assessment completed to address the resident's seatbelt. The DON said, "I thought if they could release it, no assessment had to be completed."</p> <p>2. Resident #5 was admitted to the facility 10/6/06 with diagnoses of Bipolar Disorder, Depression, Insomnia, Obesity, Status Post Cerebral Vascular Accident with left-sided Hemiparesis and Hypertension. Review of the MDS dated 2/4/10 revealed she required supervision with ambulation, and some difficulty making decisions in new situations.</p> <p>Observations of Resident #5 on 2/23/10 at 9:15 a.m., 10:20 a.m., 11:45 a.m. and 12:00 p.m., revealed her up in the wheelchair with a seatbelt secured around her waist. On 2/25/10 at 12:45 p.m., Resident #5 was observed in bed with full bed rails raised. Review of the medical record revealed the resident had not been assessed for the use of full bed rails or the use of a seatbelt.</p> <p>Interview with the AA and DON on 2/24/10 at 11:12 a.m., revealed no assessment had been completed for Resident #5 for the use of full bed rails or the seatbelt. The DON said, "I think the</p>	F 272	<p>(cont. from previous page)</p> <p>admission. All restraint and full bed rail assessments will be reviewed during the individual care plan meeting. The quality assurance committee will review 10% of resident charts monthly to ensure proper completion of assessments and compliance with time frames and physicians order.</p> <p>.....03/19/10</p> <p>REQUIRED REVISION</p> <p>The director of nursing completed restraints assessments on each resident, determined residents who had actual need for restraint, consulted physician, obtained order, implemented restraint and initiated restraint check logs and all staff educated on restraint procedures. Medical necessity is determined through the assessment and consult with physician. There were no residents identified with restraints that were not deemed medically necessary. (see attachment 13) in-service material. The quality assurance committee will review 100% of restraint assessments for 6 months and then 50% thereafter. Signs are posted on the residents door with letter of bed posted on sign. The sign reads "click it or ticket". Medical records (cont. next page)</p>	03/19/10	

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F 272	Continued From page 14 seatbelt is by her request, so an assessment is not needed." 3. Resident #6 was admitted to the facility on 12/11/07 with diagnosis of Dementia with Behaviors, Depressive Disorder, Mild Mental Retardation, Peripheral Vascular Disease, Osteoporosis, and Congestive Heart Failure. The MDS dated 12/2/09 coded the resident as having falls in the past 30 and 180 days. Observations on 2/23/10 at 9:00 a.m. and again at 5:30 p.m., revealed the resident in the bed with full length padded bed rails being used on both sides of the bed. Observation on 2/25/10 at 10:50 a.m., revealed resident lying in bed with both padded bed rails up. Review of the medical record for Resident #6 revealed no bed rail assessment was present in the chart. Interview with the Director of Nursing (DON) on 2/25/10 at 8:55 a.m., confirmed there was no assessment for the bed rails. She stated the padded bed rails were used to help prevent him from injury to his legs by the sides of the bed and were not used to keep him in the bed. 4. Review of the "Safety Device Policy" revealed a physician's order was required prior to use of any device that indicated the following, "When to use, why to use, the specific type of restraint and how long to apply." The policy did not address how the resident would be assessed for the least restrictive device and did not include bed rails as a potential restraint.	F 272	(cont. from previous page) will complete a review of the residents chart within seven days of admission.	03/19/10	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280	(F 280 to begin on next page)		

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F 280 SS=D	<p>Continued From page 15</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the plan of care was revised for two (2) of twenty (20) sampled residents. Resident #6's plan of care was not revised after a trapeze bar was discontinued and wound care was initiated. Resident #19's plan of care was not revised after she initiated a physical altercation with another resident.</p> <p>The findings include:</p> <p>1. Resident #6 was admitted to the facility on 12/11/07 with diagnosis of Dementia with</p>	F 280	<p>The facility failed to ensure the plan of care was revise for resident #6 and #19. Resident #6's care plan was updated on 03/01/10 to reflect wound care being completed on both lower extremities daily and to reflect the removal of the trapeze bar. Resident #19's care plan was updated on 03/01/10 to reflect interventions used to decrease aggressive behaviors. Medical records will review each plan of care quarterly. The quality assurance committee will review 10% of all resident charts, including the plan of care monthly to ensure accuracy and compliance.</p> <p>.....</p> <p>REQUIRED REVISION</p> <p>The interdisciplinary team was trained in proper completion and updates of care plan, by director of nursing on 03/12/10 (see attachment 14). The system was updated to add medical records review of plan of care within seven days of interdisciplinary team meeting. The medical records nurse will communicate directly with the MDS coordinator. The care plans were reviewed 03/08/10 through 03/12/10 to ensure they are correct.</p>	03/01/10
				03/12/10

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F 280	<p>Continued From page 16</p> <p>Behaviors, Depressive Disorder, Mild Mental Retardation, Diabetes with Neuropathy, Peripheral Vascular Disease and Congestive Heart Disease.</p> <p>Review of the current care plan entitled, "Alterations in self care related to disease process," revealed, "Resident uses trapeze bar and 1 side rail for bed mobility."</p> <p>Observation of Resident #6 on 2/23/10 at 9:00 a.m., and again at 2:20 p.m., revealed the resident in bed with no trapeze bar present and two (2) padded side rails in use.</p> <p>Review of the current care plan entitled, "Resident is at risk for alteration in skin integrity due to diabetes, limited mobility, obesity, PVD and incontinence of bladder," does not address wound care being provided to both lower legs.</p> <p>Review of Resident #6's Physician's Orders dated 1/20/10, revealed an order for wound care to be done to bilateral extremities every day.</p> <p>Observation of Resident #6's wound care with Licensed Practical Nurse (LPN) #4 on 2/23/10 at 2:20 p.m., confirmed wound care was being done to both lower legs.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 2/25/10 at 10:25 a.m., confirmed Resident #6 was not using a trapeze bar anymore and it (referring to the trapeze bar) needed to come off the care plan.</p> <p>He also confirmed the "alterations in skin integrity" care plan does not address the wound care.</p>	F 280			

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F 280	Continued From page 17 2. Resident #19 was admitted to the facility 10/23/09 with diagnoses of Dementia, Psychosis, Hypertension, and Morbid Obesity. Review of the medical record revealed Resident #19 initiated a physical altercation with another resident on 12/26/09. Review of the plan of care revealed no interventions were added to address the resident's aggressive behavior. This was confirmed during an interview with the Assistant Administrator (AA) on 2/25/10 at 1:00 p.m.	F 280		02/23/10	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement the plan of care for one (1) of twenty (20) sampled residents (Resident #6). The Physician's order indicated the resident was to wear heel protectors while in bed. The Physician's order was not followed. The findings include: Resident #6 was admitted to the facility on 12/11/07 with diagnosis of Dementia with Behaviors, Depressive Disorder, Peripheral Vascular Disease and Osteoporosis. Review of Resident #6's Minimum Data Set (MDS) dated 12/2/09 revealed he required extensive assistance with activities of daily living and transfers. Review of the Physician's order dated 2/5/10	F 281	The facility failed to implement the plan of care for resident #6. Heel protectors were placed on resident #6 on 02/23/10. The treatment nurse reviewed each resident with orders for heel protectors on 02/23/10 to ensure compliance with order. The treatment nurse is adding all orders for treatments to the treatment record to be initialed by the nursing staff to follow upon compliance. Treatment records will be reviewed monthly by medical records. Medical records will note areas of deficiency and report them immediately to the director of nursing. REQUIRED REVISION The wound care nurse will monitor orders and implementation of heel protectors weekly (see attachment 15). The staff was in-serviced on identification of resident (cont. next page)	03/19/10	

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F 281	Continued From page 18 revealed, "Rsd (Resident) to wear heel protectors while in bed." Observation on 2/23/10 at 2:25 p.m., revealed Resident #6 lying in bed, just prior to wound care, with heel protectors not in use. Observation on 2/25/10 at 10:50 a.m., again revealed Resident #6 lying in the bed with heel protectors not in use. Interview with Licensed Practical Nurse (LPN) # 4 on 2/23/10 at 2:25 p.m., after completion of wound care, confirmed the resident should have heel protectors in place, obtained the protectors from the closet and placed on Resident #6's heels.	F 281	(cont. from previous page) with orders of heel protectors and importance and proper placement. Boot stickers were placed on the end of each residents bed indicating the resident has an order for heel protectors and increased monitoring of placement by wound care nurse. Medical records will review the physician orders monthly and compare to treatment records to ensure compliance. The medical records nurse will report deficiencies are noted medical records will report them monthly to quality assurance committee.	03/19/10	
F 286 SS=E	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure completed Minimum Data Sets (MDS) were kept in the active medical record for the prior 15 month period for five (5) of twenty (20) sampled residents (Resident #'s 1, 2, 3, 17 and 19). The findings include: Review of the medical records for Resident #'s 1, 2, 3, 6, 17 and 19 revealed the most current MDS was not present in the medical record.	F 286	F 286 to begin The facility failed to ensure the minimum data sheets (MDS) were kept on the active medical record for the prior (15) month period for residents #1,2,3,17, and 19. (15) months of (MDS) were placed on resident #1,2,3, 17, and #19's record on 03/10/10. The medical records nurse reviewed all other resident files to ensure (15) months of (MDS) are available for review. Charts will be audited quarterly by the medical records nurse. The director of nursing will review 10% of charts monthly at random to ensure (cont. next page)	03/10/10	

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F 286	Continued From page 19 1. According to the medical record, Resident #1's last MDS assessment was completed 9/2/09. The next MDS should have been completed in 12/2009, and was not present in the medical record. 2. Review of the medical record for Resident #2 revealed there were only two (2) MDS assessments present. One was dated 2/26/09 and the other was dated 11/27/09. Fifteen (15) months were not available. 3. According to the medical record, Resident #3's last MDS was completed 10/30/09. The 1/10 assessment was not on the chart. 4. Resident # 17 was admitted 1/29/10. Review of the medical record revealed no MDS on the active medical record. 5. Review of the medical record for Resident #19 revealed the Resident Assessment Protocols (RAPS) were not present with the 11/5/09 admission assessment. Interview with the MDS Coordinator on 2/25/10 at 5:10 p.m., he said, "I don't know where it is. I knew this would come up. Things are coming up missing." The MDS Coordinator further stated all MDS assessments should be on the charts, because they had been completed. He did not know why they were all missing. He further stated the missing assessments had to be reprinted from the computer and all staff did not have access to them.	F 286	(cont. from previous page) compliance. Her findings will be reported to administration monthly. REQUIRED REVISION The MDS and medical records nurse were trained by the director of nursing. The director of nursing will report findings of chart review to the administrator and quality assurance committee monthly. If any deficiencies are found they will be corrected immediately by the quality assurance committee.	03/10/10 03/10/10	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	The facility failed to ensure resident #5 was assessed for incontinence and a plan put into (cont. next page)	03/12/10	

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NAME OF PROVIDER OR SUPPLIER GENERATIONS CENTER OF SPENCER			STREET ADDRESS, CITY, STATE, ZIP CODE 87 GENERATIONS DRIVE SPENCER, TN 38585		
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F 315	<p>Continued From page 20</p> <p>assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to ensure one (1) of twenty (20) sampled residents (Resident #5) was assessed for incontinence and a plan put in place to restore as much normal bladder function as possible.</p> <p>The findings include:</p> <p>Resident #5 was admitted to the facility 10/6/06 with diagnoses of Bipolar Disorder, Depression, Insomnia, Obesity, Status Post Cerebral Vascular Accident with left-sided Hemiparesis and Hypertension. Review of the MDS dated 2/4/10 revealed she required supervision with ambulation, had no short or long term memory deficits and was frequently incontinent of bladder.</p> <p>During an interview with Resident #5 on 2/23/10 at 4:10 p.m., she stated she was usually incontinent of bladder. The resident further stated she was aware of the need to void, but required assistance to the toilet and often times was incontinent because staff could not help her. The resident stated she would like to be able to go to the bathroom, but staff had instructed her</p>	F 315	<p>(cont. from previous page)</p> <p>place to restore as much normal bladder function as possible. Resident #5 was placed on a 3 day assessment to review voiding habits and be placed on an individualized bladder program. The nursing department assessed each resident for the potential in bladder program participation. The assessments were completed on 03/12/10. The 3 day bladder assessment will begin on admission and post change in health status to monitoring voiding patterns and evaluate for participation in individualized bowel and bladder training program. All initial assessments will be reviewed by the director of nursing. The quality assurance committee will review 10% of all resident charts monthly to ensure compliance.</p> <p>.....03/19/10</p> <p>REQUIRED REVISION</p> <p>The policy was reviewed by the administrator and director of nursing on 03-08-10 and a new assessment was developed and approved (See attachment 16). The director of nursing completed research on bowel and bladder assessments in long term care to include residents with</p> <p>(cont. next page)</p>	03/12/10	

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F 315	Continued From page 21 not to transfer herself to the toilet. Review of the medical record for Resident #5 revealed she had never been assessed for bladder retraining. The facility did not implement any interventions to improve bladder function, provide clinical justification for existing urinary incontinence, or determine the type of incontinence the resident was experiencing. Interview with the Director of Nursing (DON) on 2/25/10 at approximately 4:10 p.m. confirmed no attempts had been made to restore Resident #5's bladder function. The DON further stated no residents had been placed on a bladder retraining program.	F 315	(cont. from previous page) psychiatric diagnosis and bladder disorders. The nursing staff was retrained on the bladder assessments on 03-19-10 by assistant director of nursing. The quality assurance committee will monitor all bowel and bladder assessments for six months and the 10% thereafter to ensure compliance.	03/19/10	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure range of motion (ROM) and/or restorative services were provided for one (1) of twenty (20) sampled residents (Resident #6). The findings include:	F 318	The facility failed to ensure range of motion or restorative services were provided for resident #6. Resident #6 was spending much of his day in the bed. He is now up 3 times daily for meals and is able to self propel at times. He has been ordered to receive restorative dining and range of motion to maintain his current level of functioning and care plan updated to reflect changes in care. An additional staff member has been added to the restorative program to assist with completion of services ordered and prevent further decline in range of motion and activities of daily living in (cont. on next page)	03/09/10	

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F 318	Continued From page 22 Resident #6 was admitted to the facility on 12/11/07, with diagnoses of Dementia with Behaviors, Depressive Disorder, Mild Mental Retardation, Diabetes with Neuropathy, Peripheral Vascular Disease and Congestive Heart Failure. A review of the Minimum Data Set (MDS) dated 9/29/09, for Resident #6, revealed he was coded a 1-1 (limitation on one side with partial loss of voluntary movement) for limitations in his legs. The MDS dated 12/2/09, revealed further decline in Resident #6's ROM with a decrease in his legs to a 2-1 (limitations on both sides with partial loss of voluntary movement), and new limitations to his feet: 2-1 (limitation on both sides with partial loss of voluntary movement). Interview with the Assistant Director of Nursing (ADON) on 2/25/10 at 9:05 a.m., revealed Restorative Nursing had treated the resident, but it was for ambulation and did not address ROM. Interview with the MDS Coordinator on 2/25/10 at 10:25 a.m., revealed the Certified Nursing Assistants (CNAs) could do ROM while they were providing care, but if ROM was being done, it would be addressed on the care plan. Review of Resident #6's care plan dated December 2009 revealed ROM was not addressed.	F 318	(cont. from previous page) other residents. Residents identified with a change in health, will be evaluated for restorative therapy to maintain current level of functioning. Care plans will be updated to reflect change in health if resident does not return to prior level of functioning within 7 days. Restorative therapy will be added as ordered by the physician and placed on the plan of care. The plan of care will be reviewed by the interdisciplinary team during the care plan meeting. The quality assurance committee will review 10% of charts monthly to ensure the plan of care reflects the physician orders and to review nurses notes for change in health.	03/09/10	
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	REQUIRED REVISION Resident #5 is receiving range of motion 3 to 5 times weekly. The residents will be evaluated by the restorative nurse and restorative technician for participation in the program. The staff was in-serviced by restorative nurse that any noted decline in ADL's or mobility will be directly reported to the director of nursing for coordination with (cont. on next page)	03/09/10	

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F 323	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure residents did not have access to hot water of sufficient temperature to cause tissue injury on two (2) of three (3) halls and to ensure there was an effective monitoring system to accurately record and assess water temperatures in resident rooms. This failure had the potential to effect thirty-five (35) of sixty-seven (67) residents on the 100 and 200 halls. Hot water temperatures on the 100 and 200 halls registered between 127 and 130 degrees Fahrenheit, during the Environmental Tour, on 2/24/10 (130 degree Fahrenheit water can cause 3rd degree burns in approximately fifteen (15) seconds).</p> <p>Immediate Jeopardy was called on 2/24/10 at 2:20 p.m. Thirty-three (33) of the thirty-five (35) residents who resided on these halls had impaired decision making skills for daily living. Immediate Jeopardy was removed on 2/24/10 at 4:10 p.m., after an acceptable Credible Allegation of Compliance was received and further observations, resident interviews, staff interviews and the development of a new monitoring system was implemented by the facility. The facility remained out of compliance at a lower scope and severity of "E", a pattern deficiency with the potential for more than minimal harm, in order to complete repairs and monitoring of the water heating system.</p> <p>Additional findings, that did not rise to the level of</p>	F 323	<p>(cont. from previous page) 03/09/10 restorative nurse and technician for implementation of assessment. The restoratvie nurse will conduct weekly observations of restorative programs and report to the quality assurance committee.</p> <p>(F 323 to begin on next page)</p>		

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F 323	<p>Continued From page 24</p> <p>Immediate Jeopardy were as follows:</p> <p>The facility failed to ensure one (1) of 20 sampled residents (Resident #6) had interventions implemented after frequent falls; and failed to ensure one (1) of 20 sampled residents (Resident #9) had interventions put into place to address exit seeking behaviors, to prevent him from leaving the facility. In addition, the facility failed to ensure medications were not left unattended and the medication cart was locked on one (1) of three (3) halls where known wanderers resided.</p> <p>The findings include:</p> <p>1. During the Environmental Tour on 2/24/10 at 2:20 p.m., conducted with the Maintenance Supervisor (MS) and the Safety Officer (SO), the following hot water temperatures were observed on the 100 and 200 halls:</p> <p>Room 206- 129 degrees Fahrenheit (F) Room 201- 127 degrees F Room 203- 128 degrees F Room 117- 127 degrees F Room 104- 130 degrees F Room 103- 128 degrees F Room 114- 130 degrees F</p> <p>Upon inquiry, the MS stated he would like the hot water to register between 114 and 115 degrees F. The MS said, "We have had trouble with the mixing valve. We just changed out the circulating pump for these halls."</p> <p>Observation of the hot water heater room on 2/24/10 at 2:46 p.m., revealed the temperature at the mixing valve was 118 degrees F. The MS could not explain how water temperatures could</p>	F 323	<p>The facility failed to ensure resident #6 had interventions implemented after frequent falls. Resident #6 had additional interventions placed on his plan of care on 03-05-10 to include: alarming seatbelt on wheelchair, encourage increase participation in activities, resident will be escorted to and from all meals and activities, toileted and transferred back to bed upon return to the his room. The resident will remain on the fall awareness program. He will be reevaluated for possible changes in plan of care quarterly and post significant change or fall. The director of nursing will conduct weekly inspections of fall awareness interventions on each resident participating in the fall awareness program for the next 60 days and report findings to the quality assurance committee. The fall awareness program will continue to be monitored by the director of nursing, through random checks following the first 60 days, at least once monthly and report all findings to the safety committee.</p> <p>F 323 continued: The facility failed to ensure resident #9 had interventions in place to address exit seeking behaviors. The plan of</p> <p>(cont. next page)</p>	03-05-10	
					03-01-10

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F 323	Continued From page 25 reach 130 degrees F on the halls, when the temperature at the mixing valve was set at 118 degrees F. The MS said, "I don't think the circulating pump is working." The MS further stated that when repairs were made to the hot water system, the maintenance department completed the work, not a licensed plumber. The MS further stated the mixing valve for the 100 and 200 halls had been replaced approximately one (1) week prior. The MS said, "They go out all the time. That's why I have to change them." The MS was asked to make the Administrator aware of the hot water temperatures at this time. The MS stated, after notifying the Administrator, he was instructed to "adjust" the temperature. Review of the "Water Temperature Log", maintained by the MS, revealed weekly checks had been completed for 2009 and 2010; however, the log did not indicate in which room the water was tested. Each week the water always registered between 110 and 116 degrees F. On 2/2/10, the log indicated, under the "Comments" section, "Adjust." The MS stated on 2/24/10 at approximately 3:00 p.m., this meant the temperature was either turned up or down and this was the form he was instructed to use. The recorded water temperature on 400 hall that day was recorded as "114 and 115" degrees F. Although the facility had two (2) water heaters that serviced resident rooms, the "Water Temperature Log" did not indicate each water heater was tested on a weekly basis, nor did the log give an explanation for any adjustments that were completed. Review of the most recent Minimum Data Sets (MDS) revealed 33 of the 35 residents, who resided on the 100 and 200 halls, had modified to	F 323	(cont. from previous page) care was updated on 03-01-10 to 03-01-10 reflect the following interventions: the resident will be encouraged to increase activity participation, a yellow bracelet is located on the resident's arm and a yellow balloon is located on his door to signify he is at risk for elopement. The resident will remain on the elopement program. Orange strips were added to the exit doors to discourage exit seeking behaviors. All doors are alarmed to prevent exiting without staff awareness. Alarms are checked by the maintenance and nursing department every two hours to ensure they are working properly, the results are logged and maintained at the nurses' station. The administrator will review the log monthly to ensure compliance with completion. F 323 continued The facility failed to ensure medications were not left unattended and the medication cart was locked on one of three halls. All nurses were in-serviced on 03-01-10 on medication distribution guidelines. The inservice also included never leaving medications unattended and keeping med carts locked when unattended (see attachment D). The director of nursing will (cont. next page)	03-01-10	

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F 323	<p>Continued From page 26</p> <p>severely impaired cognitive skills for daily living. In addition, two (2) of the 33 residents were blind. The decreased cognitive status, decreased ability to communicate, and decreased reaction time put the residents at serious risk for scalding.</p> <p>The Administrator and Assistant Administrator were notified of the Immediate Jeopardy on 2/24/10 at 3:15 p.m.. At this time the Administrator stated the MS had no formal qualifications to perform repairs on the facility's hot water system, but did have on the job experience. The Administrator further stated the maintenance department had turned down the water temperature and had rechecked all rooms to ensure the water was not too hot and a check would be completed every four (4) hours until the system was working properly.</p> <p>At approximately 3:30 p.m., on 2/24/10 during a confidential interview, Unsamped Resident Z said, "I have never been burned by the water in my bathroom. I make instant coffee, using tap water every morning. I like my coffee good and hot."</p> <p>On 2/24/10 between 3:35 p.m. and 3:45 p.m., two (2) Licensed Practical Nurses and three (3) Certified Nursing Assistants, who worked on the 100 and 200 halls were interviewed about hot water temperatures. None of the staff members were aware of anyone who had been burned by the water in the bathroom sinks.</p> <p>The facility's Credible Allegation of Compliance was approved 2/24/10 at 4:10 p.m. The Credible Allegation of Compliance included the following:</p> <p>The water valve mixer was recalibrated and water</p>	F 323	<p>(cont. from previous page)</p> <p>complete weekly checks of each med cart to ensure they are locked when unattended for the first 30 days following the in-service and then monthly at random thereafter. The quality assurance committee and safety officer will also check med carts for unattended medications and to ensure the cart is locked when unattended.</p> <p>.....03-19-10</p> <p>REQUIRED REVISION</p> <p>All staff was in-serviced on 03-19-10 on proper reporting of water temperatures. The maintenance department was in-serviced on 03-19-10 for proper reporting and monitoring of water temperatures (See attachment 17). Routine temperatures are monitored Monday, Wednesday and Friday. Findings will be reviewed during safety meeting and reported to the quality assurance committee monthly. The quality assurance committee will review the temperature monitoring log to ensure compliance.</p> <p>Resident #6 assessment for seatbelt (See attachment 18). The director of nursing will reevaluate for continued use of seatbelt. The nursing staff was reeducated on the fall</p> <p>(cont. on next page)</p>	03-01-10	

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F 323	<p>Continued From page 27</p> <p>temperatures immediately came down to 107 degrees. A licensed plumber was called and will be evaluating the system. The MS checked the water temperatures in every room to ensure all were within state and federal guidelines. Water temperatures will continue to be monitored and recorded by the MS, with the location noted on the "Water Temperature Log." Effective immediately, following all maintenance or repairs on water heaters, water temperatures will be monitored every four hours for the first seven days and findings reported to the Administrator daily. A licensed plumber will complete all repairs. The Administrator will check water temperatures at random, weekly and monitor logs monthly to ensure compliance. The findings will be reviewed during the monthly safety and Quality Assurance meetings.</p> <p>Observations of water temperatures were conducted on 2/24/10 at 4:20 p.m. Water temperatures on the 100/200 hall ranged from 104-107 degrees F.</p> <p>Further deficient practice, which did not rise to an Immediate Jeopardy, included:</p> <p>2. Resident #6 was admitted to the facility on 12/11/07 with diagnoses of Dementia with Behaviors, Depressive Disorder, Mild Mental Retardation, Diabetes with Neuropathy, Peripheral Vascular Disease and Congestive Heart Failure. The resident's quarterly Minimum Data Set (MDS) dated 9/29/09 and the annual MDS dated 12/2/09, coded the resident with short and long term memory problems with moderately impaired cognitive skills for decision making.</p> <p>According to Resident #6's Nurses Notes dated</p>	F 323	<p>(cont. from previous page) 03-19-10</p> <p>program and restraint assessment protocol on 03-19-10 by the assistant director of nursing (See attachment 19). The facility re-introduced the weekly meetings for follow up on all falls. All falls are being assessed on an individualized basis by the fall committee within 24 hours and interventions initiated and added to the plan of care. The decision to implement interventions and place restraints as medically necessary will be determined by the director of nursing, resident's physician and interdisciplinary team. The care plan team was reeducated on care plan procedures (See attachment 14). The quality assurance committee will review 100% of resident care plans with exit seeking behavior. The safety committee reports to the quality assurance committee monthly and the safety officer participates in all quality assurance meetings. The nursing staff was reeducated on 03-19-10 by the assistant director of nursing. The facility has increased staff observation of resident to include 15 minute checks of resident location when out of bed. The staff will encourage increase activity participation. (cont. on next page)</p>		

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F 323	<p>Continued From page 28</p> <p>11/22/09 at 1:40 p.m., the resident slid into the floor while attempting to get into bed. No injury was noted. No incident report was available for review. Review of the care plans dated September 2009 revealed no new interventions were put into place after the fall occurred.</p> <p>According to Resident #6's Nurse's Notes dated 12/14/09 at 1:15 p.m., the resident was found lying in the doorway to his room. Resident reported he had come out of the bathroom walking behind his wheelchair with regular socks on and slid down. No injuries were noted. No incident report was available for review. Review of the care plans dated December 2009 revealed no new interventions were put into place after the fall occurred.</p> <p>According to Resident #6's Nurse's Notes dated 2/19/10 at 8:30 a.m., the Certified Nursing Assistant (CNA) reported finding the resident sitting on the floor of his bathroom. Assessment of the resident revealed an old skin tear had been reopened and he had a red mark on his buttock. No other injuries were noted. The incident report dated 2/22/10, indicated the Director of Nursing (DON) spoke with the staff and MDS Coordinator and resident will be assessed for the need of restorative and bowel and bladder programs. Review of the care plans dated December 2009 revealed no new interventions were put into place after the fall occurred.</p> <p>According to Resident #6's Nurse's Notes dated 2/21/10 at 6:10 p.m., the CNA found the resident lying on the bathroom floor. The resident stated he was trying to get on the toilet. No injuries were noted. The incident report dated 2/22/10, indicated the patient will be assisted back to his</p>	F 323	(cont. from previous page) 03-19-10 Conservator has been notified of need of a busy board and states she will supply one. The interdisciplinary team will evaluate effectiveness of interventions over the next 30 days.		

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F 323	<p>Continued From page 29</p> <p>room from the dining room, toileted and placed in bed after meals. Review of the care plans dated December 2009 revealed no new interventions were put into place after the fall occurred.</p> <p>3. Resident #9 was admitted to the facility on 8/1/08 with diagnoses of Dementia, Psychosis, Anoxic Brain Injury, Hyperthyroidism, Gastritis, Congestive Heart Failure, Liver Encephalitis. The resident was coded on the Minimum Data Set (MDS) dated 2/11/10 as requiring extensive assistance with dressing and hygiene, total dependence with bathing as well as incontinent of bowel and bladder. In addition, the resident was coded as exhibiting a behavior of wandering on a daily basis.</p> <p>During initial tour on 2/22/10 at 1:35 p.m., Resident #9 was observed wandering in and out of other resident rooms throughout the facility. He also took a bag of tubing from the top of the medication cart. On 2/24/10 at 12:17 p.m., Resident #9 was observed in Room 206 standing over bed B, this was not his room. Review of Nurse's Notes dated 11/14/09, 12/18/09, 1/1/10, and 1/22/10 revealed Resident #9 had a daily behavior of wandering in and out of other resident rooms, as well as setting of exit door alarms.</p> <p>During the group interview on 2/24/10 at 9:30 a.m., eight (8) of eight (8) residents present stated Resident #9 constantly entered their rooms and removed items. During an interview on 2/25/10 at 9:11 a.m., Case Manager (CM) A shared Resident #9 set off exit door alarms one (1) or two (2) times per week and exited the doors at least once per month. CM A further explained a staff member would redirect Resident #9 to re-enter the facility as soon as he exited outside</p>	F 323			

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F 323	<p>Continued From page 30 the door.</p> <p>During an interview with the Assistant Administrator (AA) on 2/24/10 at 2:25 p.m., she explained Resident #9 had no "Elopement Incident/Event Reports" since he never left the facility grounds when he exited facility doors.</p> <p>Review of the "Elopement Summary Assessment" revealed Resident #9 exited the facility 5/28/09, 8/21/09, and 11/13/09.</p> <p>Review of the plan of care dated 2/11/10 revealed the facility familiarized the resident with his own room, encouraged group activities, and monitored his location every two hours. However, when these attempts were unsuccessful, no changes were made to the plan of care to keep him safe from exiting the building or getting injured related to his wandering into other resident rooms. In addition, no plan was put into place to ensure Resident #9's safety when other residents became angry with him for taking their things. The facility continued to "redirect" the resident, although this approach was ineffective.</p> <p>4. During Medication Pass of Unsampled Resident (USR) #A on 2/24/10 at 4:15 p.m., Licensed Practical Nurse (LPN) #3 was observed leaving medications, Lasix 20 milligrams (mg) and Gabapentin 300 mg, unattended on top of the medication cart while she went to a supply area to obtain gloves. Wandering residents were observed in the area of the medication cart at the time. Interview with LPN #3 after completion of the medication pass revealed she would not normally do that (referring to leaving medications unattended).</p>	F 323			

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F 332	Continued From page 32 revealed an order for Tylenol 500 mgs, not the 325 mgs that was given. 2. Unsampled Resident #B received Risperidone one (1) mg during this medication pass. Review of the Physician's orders for the resident revealed an order for Risperidone 1 mg at bedtime, not at 4:10 p.m. During Medication Pass observation conducted with LPN #2 on 2/24/10 beginning at 3:55 p.m., the following medication error was observed: 3. Unsampled Resident #C received 2.5 mgs of Buspirone. Review of the current Physician's orders for this resident revealed an order for Buspirone 5 mgs to be given in the evening, not the 2.5 mgs that was given. Interview with LPN #2 on 2/24/10 at 5:00 p.m., confirmed she had only given a half tablet of Buspirone, which was 2.5 mgs. LPN #2 said, "I need to give her another half" Interview with the Director of Nursing (DON) on 2/25/10 at 8:55 a.m., revealed she knew she had some problems with medication administration.	F 332	REQUIRED REVISION The director of nursing conducted the in-service. All nurses were required to complete a medication pass competency exam following the in-service. The pharmacist creates medication error reports. A copy of the medication error report is (attachment 20). The medication error report will be reviewed by the director of nursing and her findings reported to the quality assurance committee to guide as needed in future education of proper medication administration for all nurses. The pharmacist will participate in quarterly quality assurance meetings and continue to provide monthly medication error reports. The pharmacist will also observe medication administration monthly.	03-15-10	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356	The facility failed to ensure nursing staffing data was posted on a daily basis and was located in a prominent place. The nursing staffing data was moved from the front lobby to the nurses station on 02-26-10. The safety officer will monitor for placement and completion of the nursing staffing data forms during weekly walk through for (cont. next page)	03-01-10	

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F 356	Continued From page 33 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nurse staffing data was posted on a daily basis, contained the resident census and was located in a prominent place, readily accessible to residents and visitors for four (4) of five (5) days of the survey. The findings include: The nurse staffing information was not observed posted in the facility from 2/22-25/10. Interview with the Assistant Administrator (AA) on 2/15/10 at 8:50 a.m., revealed the Director of Nursing (DON) was responsible for the nurse staffing information. The AA asked the DON where the	F 356	(cont. from previous page) the next 90 days and monthly thereafter to ensure compliance. REQUIRED REVISION The nursing staff was re-educated location and proper completion of the nursing staffing data form on 03-19-10 (See attachment 17). The nursing staff will complete the form at the beginning of each shift. The quality assurance committee will review the safety officer's findings monthly.	03-01-10	03-19-10

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F 356	Continued From page 34 information was posted at this time. The nurse staffing information was located in the front lobby, on a clipboard, outside the Administrator's office. Review of the information revealed the census had not been listed for the month of February 2010. In addition, the staffing information had not been posted for 2/25/10. The AA agreed the nurse staffing information was not located in a prominent place and was not readily accessible to residents, since they did not have the code to get out to the lobby.	F 356			
F 368 SS-E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on group interview and staff interview, the facility failed to offer each resident a bedtime snack every day. Eight (8) of eight (8) residents present in the group interview complained of not	F 368	The facility failed to offer each resident a bed time snack every day. The director of nursing and dietary manager educated all staff to offer each individual resident snacks at bed time. The overhead announcement will continue to be used to alert staff the snacks are available at the nurses' station for distribution. An additional in-service was conducted on 03-19-10 on the importance of snack distribution and the procedure of offering in rooms. The director of nursing and dietary manager will complete weekly inspections of bed time snack distribution for the first 30 days and then quarterly random checks will be completed thereafter to maintain compliance. The quality assurance committee will survey 10% of residents monthly to ensure there are no (cont. next page)	03-19-10	

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F 368	Continued From page 35 being offered a bedtime snack. The findings include: During the group interview on 2/24/10 at 9:30 a.m., the eight (8) of eight (8) residents in attendance complained bedtime snacks were not consistently offered every day. The residents stated sometimes they had a snack and sometimes they did not. During interview on 2/25/10 at 9:50 a.m., the Director of Nursing (DON) and Assistant Administrator (AA) explained their procedure was for a nursing staff member to make a "Snack of the Day" announcement and the nursing staff would distribute a snack to any resident who came to the nursing station at that time. The DON nor AA could explain how bed-bound residents received a snack. The DON indicated nursing staff did not go room to room to offer a snack.	F 368	(cont. from previous page) complaints related to snack distribution. REQUIRED REVISION The nursing staff began going room to room to ensure all residents are offered a bed time snack. In-service was conducted on 03-19-10 by the assistant director of nursing (See attachment 17). The director of nursing and dietary manager will conduct weekly observations of 8:00 p.m. snack distribution at random to ensure compliance. The quality assurance committee will survey all who are cognitively able to participate in survey. The dietary manager will report all findings of random observations to the quality assurance committee monthly.	03-19-10 03-19-10	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	The facility failed to provide clean tables in the dining room and failed to prevent infections during insulin administration. On 02-26-10 the cleaning system was reorganized to include: proper sanitation of each table before a resident is assisted to the table and sweeping and mopping of floors between first and second dining. The maintenance director and dietary manager will monitor the new (cont. next page)	03-01-10	

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F 441	<p>Continued From page 37</p> <p>cleaned/sanitized prior to the residents placement for the second (2nd) seating for lunch. In addition, dirty dishes remained on five (5) tables and four (4) other tables were not cleaned/sanitized. Also, food debris was on the floor throughout the dining room due to staff brushing it off the tables prior the second (2nd) seating for lunch. The staff was observed to get sanitizing cloths from a container on the wall. When the tables were wiped with the cloths, there was no visible moisture. Observation of the cloths revealed they were completely dry. Upon inquiry, product information was provided. The product information indicated the product should be stored in a manner to prevent it from "drying out." The Maintenance Worker stated the wipes had been stored incorrectly and were not effective.</p> <p>During interview on 1/24/10 at 4:05 p.m., the Dietary Manager (DM) confirmed the tables and floors should have been cleaned/sanitized prior to the second (2nd) seating of lunch in the dining room.</p> <p>2. Licensed Practical Nurse (LPN) #3 was observed during Medication Pass on 2/23/10 at 4:25 p.m., administering an Insulin injection to Unsampld Resident #A with no gloves on.</p> <p>Interview with LPN #3 after she completed the medication pass for Unsampld Resident #A, confirmed she would normally wear gloves to administer Insulin, but had forgotten to wear them this time.</p> <p>Review of Infection Control Policy entitled, "General Infection Control Policy Statements," revealed "nursing personnel will maintain the highest levels of professional hygiene." No other</p>	F 441	<p>REQUIRED REVISION</p> <p>The staff was re-educated on the updated cleaning system on 03-19-10 by the assistant administrator (See attachment 17 and 22). The nursing staff was re-educated on 03-01-10 by the director of nursing on medication administration procedures. The director of nursing completed monitoring of insulin administration on 03-18-10.</p>	03-19-10	

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F 441	Continued From page 38	F 441			
F 490	483.75 EFFECTIVE	F 490	The facility failed to be	03-19-10	
SS=K	ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to be administered in a manner that ensured staff had a system in place to monitor hot water temperatures in resident rooms and resident care areas, and adequately monitor repairs on the hot water heaters, which placed residents at risk for serious harm related to excessive water temperatures. Immediate Jeopardy was called on 2/24/10 at 2:20 p.m., after water temperatures ranging from 127 degrees Fahrenheit to 130 degrees Fahrenheit were observed on the 100 and 200 halls. Thirty-three (33) of the thirty-five (35) residents who resided on these halls had impaired decision making skills for daily living. Immediate Jeopardy was removed on 2/24/10 at 4:10 p.m., after an acceptable Credible Allegation of Compliance was received and further observations, resident interviews, staff interviews and the development of a new monitoring system was implemented by the facility. The facility remained out of compliance at a lower scope and severity of "E", a pattern deficiency with the potential for more than minimal harm, in order to complete repairs and monitoring of the water		administered in a manner that ensured staff had a system in place to monitor hot water temperatures in resident rooms and resident care areas and adequately monitor repairs on the hot water heaters. The water valve mixer was recalibrated and water temperatures immediately came down to 107 degrees. A licensed plumber evaluated the system on 02-24-10 and found no problems. The maintenance director checked water temperatures in every room to ensure all were within state and federal guidelines. Water temperatures will continue to be monitored and recorded by the maintenance director with the location noted on the water temperature log. Water temperatures will be monitored following all repairs on the water heater and system, every four hours for the first 7 days with findings reported to the administrator daily. A licensed plumber will complete all repairs. The administrator will check water temperatures at random weekly and monitor logs to ensure compliance. Findings will be reviewed monthly (cont. next page)		

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F 49D	Continued From page 40 2. The facility had no system in place to adequately monitor repairs of the hot water heaters. Observation of the hot water heater room on 2/24/10 at 2:46 p.m., revealed the temperature at the mixing valve was 118 degrees F. The MS could not explain how water temperatures could reach 130 degrees F on the halls, when the temperature at the mixing valve registered 118 degrees F. The MS said, "I don't think the circulating pump is working." The MS further stated that when repairs were made to the hot water system, the maintenance department completed the work, not a licensed plumber. The MS further stated the mixing valve for the 100 and 200 halls had been replaced approximately one (1) week prior. The MS said, "They go out all the time. That's why I have to change them." The MS stated the facility did not secure services of a licensed plumber to address the continued problems. The MS stated there was no monitoring of repairs to ensure everything worked correctly.	F 49D			
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	The facility failed to ensure a quality assurance committee identified the need to monitor repairs of the hot water heating system to ensure safe temperature parameters were maintained. The water valve mixer was recalibrated and water temperatures immediately came down to 107 degrees. A licensed plumber will complete all future repairs. The licensed plumber completed an evaluation of the system on 02-24-10 and found no problems. The maintenance director checked water (cont. next page)		03-11-10

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F 520	Continued From page 42 The findings include: 1. (Cross Refer F323 Example #1). During an interview with the Maintenance Supervisor (MS) on 2/24/10 at 2:46 p.m., he stated when repairs were made to the hot water system, the maintenance department completed the work, not a licensed plumber. The MS also said, "I don't think the circulating pump is working." The MS further stated the mixing valve for the 100 and 200 halls had been replaced approximately one (1) week prior and, "They (mixing valves) go out all the time. That's why I have to change them." The MS confirmed there were frequent problems with the hot water heating system and the facility had not secured the services of a licensed plumber to address the continued problems. 2. Interview with the Director of Nursing (DON) and the QA Licensed Practical Nurse (LPN) on 2/25/10 at 10:45 a.m., revealed problems with the hot water had not been addressed by the QA Committee. The DON stated both she and the QA LPN were new to their positions, but did not recall any QA action regarding monitoring hot water. The DON stated all departments had access to the QA Committee and the MS did attend the meetings. The DON agreed frequent repairs to the hot water system would require QA activity to determine why the system needed repair so frequently. Although members of the QA Committee were aware of the frequent problems with the hot water heating system, no QA activity was initiated to ensure safe water temperatures were maintained in the facility. The DON could find no evidence of hot water repairs or water temperature reports brought to the QA Committee.	F 520	(cont. from previous page) 1. Placement of survey results 2. Complete investigations of all injuries of an unknown origin 3. All resident to resident altercations 4. Labeling of resident items 5. Linen quality 6. 15 months of MDS 7. Bowel and bladder, restraint, side rail assessments 8. Restorative discharges 9. Water temperatures 10. Nursing data form placement 11. Education of new hires 12. Snack distribution quality 13. Increasing number of meetings until complete review of current policies and standards is revised. The changes made for review in the water temperature guidelines were: a licensed plumber will complete all maintenance on the water heater system, the temperatures will be checked by a member of maintenance every four hours for the first seven days post maintenance on water heater system, the administrator will monitor water temperatures weekly and logs monthly. Then routine water temperatures will be monitored Monday, Wednesday and Friday, weekly. (See attachment 21)	03-11-10

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